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**MEDICAL HISTORY**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_Sex: \_\_\_\_Weight: \_\_\_\_\_\_Height: \_\_\_\_\_\_**

**Reason for today’s visit** (Please circle one): RASH MOLES BUMPS SKIN CANCER PSORIASIS ACNE COSMETIC: Botox/Xeomin/Dysport Fillers Kybella Hair Loss Treatment Skin tightening Weight Loss OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred By**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or **Found us on**: Web Facebook Instagram Groupon **Other**: \_\_\_\_\_\_\_\_\_\_\_\_

**Medications** (Please List):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**: Are you allergic to medications? No \_\_\_\_Yes\_\_\_\_\_(Please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reaction \* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have general allergies? No \_\_\_\_Yes\_\_\_\_\_(Please List)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diet:** Please describe your normal daily diet:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin History**: (Please Check)

Have you ever visited a Dermatologist? No \_\_\_\_\_Yes\_\_\_\_\_ Reasons / Approx date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had skin cancer? No \_\_\_\_\_Yes\_\_\_\_\_ Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do have a history of specific skin disease? No \_\_\_\_\_Yes\_\_\_\_\_ Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you form Keloids (thick scars)? No \_\_\_\_\_Yes\_\_\_\_\_ Do you regularly use sunscreen? No \_\_\_ Yes \_\_\_

Have you ever had blistering sunburn? No \_\_\_\_\_Yes\_\_\_\_\_ Do you actively “seek a tan”? No \_\_\_ Yes \_\_\_

When exposed to the sun, do you? Tan only\_\_\_\_\_\_ Tan and Burn\_\_\_\_\_\_\_\_ Burn \_\_\_\_\_\_\_\_

Please describe your current sun exposure in the last 2 years: Minimal \_\_\_\_\_ Moderate \_\_\_\_\_\_Maximal \_\_\_\_\_\_

Please describe your childhood sun exposure (first 18 years): Minimal \_\_\_\_\_ Moderate \_\_\_\_\_\_Maximal \_\_\_\_\_\_

**General Medical:** Do you now have, or have you ever had (Please Check)?

Asthma No \_\_\_\_Yes\_\_\_\_ Seizures No \_\_\_\_ Yes\_\_\_\_ Arthritis No\_\_\_\_ Yes\_\_\_\_

Seasonal allergies No \_\_\_\_Yes\_\_\_\_ Depression No \_\_\_\_Yes\_\_\_\_ Ulcers/reflux No \_\_\_\_Yes\_\_\_\_

High BP No \_\_\_\_Yes\_\_\_\_ Thyroid disease No \_\_\_\_Yes\_\_\_\_ Fever Blisters No \_\_\_\_Yes\_\_\_\_

Phlebitis No \_\_\_\_Yes\_\_\_\_ Diabetes No \_\_\_\_ Yes\_\_\_\_ HIV infection No \_\_\_\_Yes\_\_\_\_

Cataracts No \_\_\_\_Yes\_\_\_\_ Glaucoma No \_\_\_\_ Yes\_\_\_\_ Cancer No \_\_\_\_Yes\_\_\_\_

Heart Valve Disorder No \_\_\_\_Yes\_\_\_\_ Hepatitis No \_\_\_\_ Yes\_\_\_\_

Have you ever had local anesthesia? No \_\_\_\_\_\_Yes \_\_\_\_\_\_\_Did you have a bad reaction? No\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take antibiotics before dental appointments? No \_\_\_\_Yes\_\_\_\_ Do you smoke? No \_\_\_\_ Yes\_\_\_\_\_

Are you pregnant or breastfeeding? No \_\_\_\_\_ Yes \_\_\_\_\_ Do you drink alcohol? No \_\_\_\_Yes\_\_\_\_\_

List surgical procedures you have had in the last 6 months:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medical conditions you are currently being treated for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**:

Do you or any blood relatives have a history with skin cancer? No \_\_\_\_ Yes\_\_\_\_\_ Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family members with Cerebral Arterial Disease \_\_\_\_\_\_ High Blood Pressure \_\_\_\_ Diabetes \_\_\_\_\_ Cancer \_\_\_\_\_\_

Marital status: Single \_\_\_\_\_ Married\_\_\_\_\_\_ Divorced \_\_\_\_\_\_ Widowed \_\_\_\_\_\_\_ Partnered\_\_\_\_\_\_

Do you have any children? No \_\_\_\_\_ Yes\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient / Guardian Signature Date

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Reviewing Staff Initials Date